

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

02934

CERTIFICATE OF DEATH

Reg. Dist. No. 2040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Kent

City or town Chestertown (R. F. D. *Fairlee)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Anna Atkinson

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white married

6. (b) Name of husband or wife Charles Atkinson

living

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 30, 1882

8. AGE: Years Months Days If less than one day
64 II 3 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name William Krach

13. Birthplace Germany

14. Maiden name Charlotte Lamm

15. Birthplace Germany

16. Informant Mr. Charles Atkinson

Address Chestertown, Maryland

17. Burial Date thereof Mar. 6, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Saint Paul Cem.

Location near - Chestertown, Maryland

18. Funeral director J. Willis Wells

Address Chestertown, Maryland

19. Mar. 6 1947
(Date rec'd by registrar)F. O. Smith
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town near - Chestertown
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 3 1947 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 23 1947 to Mar. 3 1947

and that I last saw her alive on Mar. 28 1947

Immediate cause of death

Stroke - Myocarditis
Decompression

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

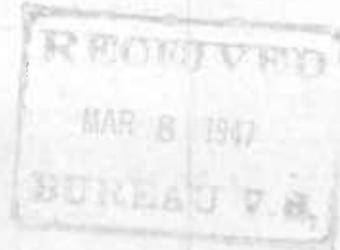
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE above a Burgard

M. D. mother

Address Rock Hall, Md. Date signed 3/3/47



1 - 35 -

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

02935

CERTIFICATE OF DEATH

Reg. Dist. No. 2020C

1. PLACE OF DEATH: Kent
 County.....
 City or town..... Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 39 days
 Hospital, Institution, or street address where death occurred:
 Kent and Queen Annes
 How long in hospital or institution? 39 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Kent
 City or town Rural - Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Quaker Neck Way
 (If rural, give LOCATION)

3. (a) FULL NAME
 William Benjamin Franklin CRANOR
 4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elizabeth Ellen CRANOR
 7. Birth date of deceased (mo., day, yr.) JUNE 6, 1871
 6. (c) If alive, give age years

8. AGE: Years 75 Months 9 Days 2 If less than one day hrs. min.

9. Birthplace Fairlee Kent Maryland
 (Town, county, and state)

10. Usual occupation Waterman

11. Industry or business Oyster

MOTHER FATHER
 12. Name Charles E. CRANOR

13. Birthplace Queen Anne's County, Maryland

14. Maiden name Mary Virginia Butler

15. Birthplace Kent County, Maryland

16. Informant Hospital Records

Address Chestertown, Md.

17. Burial Date thereof March 16, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or cemetery St. John's Catholic Cemetery

Location Rock Hall, Kent Co. Md.

18. Funeral director Martin V. Williams

Address Chestertown, Maryland

19. March 9, 1947 Date rec'd by registrar

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1947 at 11:42 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 29, 1947, to March 8, 1947, and that I last saw him alive on March 8, 1947.

Immediate cause of death Circulatory collapse
 Chronic myocarditis
 Due to Hypertension

Due to Arteriosclerosis

Other conditions Cancer of colon

(Include pregnancy within 3 months of death)

Major findings of operations Cancer of recto-sigmoid colon

Date of op. 3-3-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

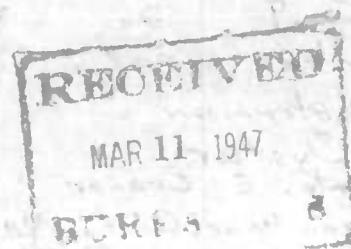
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Al. Dick M. D. or other

Address Chestertown, Md. Date signed 3-8-47



1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

62936

CERTIFICATE OF DEATH

Reg. Dist. No. 2020

1. PLACE OF DEATH

County Kent

City or town Chestertown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred:

Kent & Queen Anne Hospital

How long in hospital or institution? 12 days

3. (a) FULL NAME

Carrie Elizabeth Hicks

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

W.

married

B. (b) Name of husband or wife

Clyde D. Hicks

7. Birth date of deceased (mo., day, yr.)

Aug 30, 1889

6. (c) If alive, give age 60 years

8. AGE:

| | | | |
|-------------|-------------|------------|--------------------------------------|
| Years 57 | Months 7 | Days 22 | If less than one day hrs. min. |
|-------------|-------------|------------|--------------------------------------|

9. Birthplace

Winchester, Frederick Co., Va.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

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MAR 12 1947

BUREAU V 6

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02937

CERTIFICATE OF DEATH

Reg. Dist. No.

2040

1. PLACE OF DEATH: Kent
 County _____
 City or town: Tower Chestertown MD
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 28 years
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent
 City or town: Tower Chestertown MD
(If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
(If rural, give LOCATION)

3. (a) FULL NAME

Edward C Jones
 4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Married
Widowed & Wallace
 8. (b) Name of husband or wife: Widowed & Wallace
 7. Birth date of deceased (mo., day, yr.): October 7, 1878 8. (c) If alive, give age 63 years
 8. AGE: Years 68 Months 5 Days 4 If less than one day
 hrs. _____ min. _____
 9. Birthplace: Tower Chestertown
 (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER: 12. Name: Josephine Jones
 13. Birthplace: Tower Chestertown
 MOTHER: 14. Maiden name: Josephine Thompson
 15. Birthplace: Tower Chestertown
 16. Informant: Born Ed. Jones
 Address: Chestertown

17. Burial: Burial Date thereof: 3 - 13 - 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Holmes

Location: Holmes Maryland

18. Funeral director: J. Willis Weeks
 Address: Chestertown Maryland

19. Date rec'd by registrar: Mar. 12, 1947 Registrar: F. K. Smith
(Date rec'd by registrar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to March 1947 and that I last saw him alive on March 10, 1947

Immediate cause of death: Appendectomy
 Due to: Cardiac Arrest Duration: 3 days

Due to: Deceased Duration: 2 years

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury: _____ Injured at work? _____

23. SIGNATURE: Frank W. Smith M. D. or other _____

Address: Chestertown Date signed: Mar. 14, 1947

RECEIVED BY TELETYPE STATE DEPARTMENT

TELETYPE WIREGRAM
TO THE STATION

RECEIVED

MAR 14 1947

BUREAU OF INVESTIGATION

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

02938

CERTIFICATE OF DEATH

Reg. Dist. No. 2801

1. PLACE OF DEATH:

County.....

City or town.....

Kent
Massey Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Russell Kelly

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Evelyn P Kelly

7. Birth date of

deceased (mo., day, yr.)

March 9 1902

8. AGE:

Years

Months

Days

If less than one day

45

0

3

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Lydia

Massey

13. Birthplace

Lydia

Massey

14. Maiden name

Lydia

McAllister

15. Birthplace

Lydia

Massey

16. Informant

Evelyn

Massey

17. Burial

Massey

18. Funeral director

Edward Fellows

Address

Millington

Md

19. Date rec'd by registrar

March 19

1947

(Date rec'd by registrar)

Edward Fellows

Deputy

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

716-01-3147

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 12 1947, at 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 8 1947, to March 12 1947

and that I last saw him alive on March 12 1947

Immediate cause of death

Concussion Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. P. Coffland M. D. or other

Address

Wellesley Date signed March 19 1947

RECEIVED

MAR 27 1947

2-25

2-2000 - 2-18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

02939

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County.....

Kent

City or town.....

Rock Hall, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

28 years

Hospital, institution, or street address where death occurred:

Hansen

How long in hospital or institution?.....

3. (a) FULL NAME

Charles Willard Mc Clary

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.

white

married

6. (b) Name of husband or wife.....

Emilia Mc Clary

6. (c) If alive, give age..... 65 years

7. Birth date of deceased (mo., day, yr.)

Dec 23 1873

8. AGE:

Years
73Months
2Days
18

If less than one day

hrs. min.

9. Birthplace.....

Stillpond, Md

(Town, county, and state)

10. Usual occupation.....

retired

11. Industry or business

MOTHER FATHER

Josua Mc Clary

12. Name.....

not known

13. Birthplace.....

Josia May Anderson

14. Maiden name.....

Wilmington, Del

15. Birthplace.....

Wilmington, Del

16. Informant.....

Wm. Mc Clary

Address

Rock Hall, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 3 13 1947
(month) (day) (year)

Cemetery or crematory.....

Worley Chapel

Location.....

Rock Hall, Md

18. Funeral director.....

Edgar L. Lane

Address

Colmar Hill, Md

19. (Date rec'd by registrar)

1947

Registrar

S. Elwood Burgard

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Kent

City or town.....

Rock Hall, Rural

Street No.....

Haven

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

March 10 1947 at 10³⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 26 1947 to March 10 1947

and that I last saw him alive on March 10 1947

Immediate cause of death.....

chronic endo-myocarditis

Concussion of the brain

Due to..... Fall from roof

Due to..... Gout

Other conditions..... sepi-Osmurb-bladder

mental deficiency arteriosclerosis).

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Mar 26 1947 Date of 2/26/47

Where did injury occur..... Rock Hall Kent 3rd

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) house

Means of injury..... Fall from roof Injured at work? no

23. SIGNATURE..... Albert A Burgard M. D. or other

Address..... Rock Hall, Md Date signed 3/10/47

RECEIVED

MAR 22 1947

2-25-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

02940

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH: Kent
 County
 City or townLynch
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 38 yrs.
 Hospital, Institution, or street address where death occurred: Lynch
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Kent
 City or townLynch
(If outside city or town limits, write RURAL and give nearest town)
 Street No.Lynch
(If rural, give LOCATION)

3. (a) FULL NAME

Thomas John Oliver4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife, (late) Ruth A. Oliver7. Birth date of deceased (mo., day, yr.) August 23 1856 6.(c) If alive, give age years8. AGE: Years 90 Months 7 Days 0 If less than one day hrs. min.9. Birthplace Hartford Co. Maryland
(Town, county, and state)10. Usual occupation Canner Patriot11. Industry or business Packing Tomatoes12. Name William Oliver13. Birthplace Scotland14. Maiden name Sarah Mac Coy15. Birthplace Scotland16. Informant Miss Margaret Oliver (daughter)Address Lynch, Kent Co. Md.17. Burial Burial Date thereof March 26, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary'sLocation Concordia Hartford Co. Md.18. Funeral director Marie V. WilliamsAddress Chesapeake, Maryland19. March 25, 1947 (Date rec'd by registrar) Clara S. Barnes Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947 at 1:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1946 to March 22 1947 and that I last saw him alive on March 22 1947Immediate cause of death Chronic Myocarditis DURATION 5 moDue to Unterminated 2 moDue to General EdemaOther conditions General Edema

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

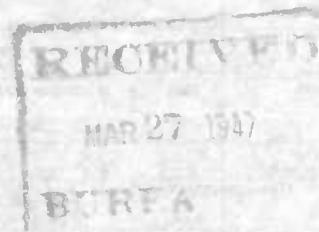
Means of injury Injured at work?

23. SIGNATURE Frank W. Smith M. D. MotherAddress Chesapeake Date signed 25/47

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HEADQUARTERS OF THE UNITED STATES GOVERNMENT



1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

U2943

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County.....

City or town.....

Chestertown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Kent & Queen Anne to Hospital

How long in hospital or Institution?.....

13 days

3. (a) FULL NAME

John Wesley Pine

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Widowed -

6. (b) Name of husband or wife.....

Mattie Coleman

B. (c) If alive, give age 18 years

7. Birth date of

deceased (mo., day, yr.)

Unknown 1889

8. AGE:

Years
58

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Unknown

(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business

Farm

12. Name.....

Alec Pine

13. Birthplace.....

Unknown

14. Maiden name.....

Unknown

15. Birthplace.....

Unknown

16. Informant.....

Decedent

Address

Kennedyville Md.

17. Burial.....

Date thereof Mar 29 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Coleman

Location.....

Norton and Rural

18. Funeral director.....

B. R. Fellows

Address

Still Pond Md.

19. Date rec'd by registrar.....

Mar. 28 1947

Clara L Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Kent

City or town.....

Edgewater Md.

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

3-25

19.

47

8-10

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-12

19.

47

to 3-25

19.47

and that I last saw him alive on 3-25

19.

47

Immediate cause of death.....

Gangrene - left leg foot

DURATION

13 days

Due to Diabetes mellitus.

Arteriosclerosis, characterized by gangrene in adequate peripheral arterial circulation -

unbroken

Due to

Injury

unbroken

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations Amputation left leg - mid thigh

Date of op.

3-24-47

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

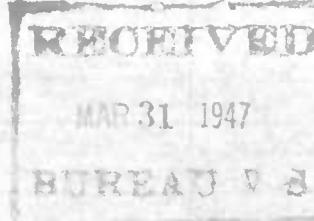
Ruth Dean

M. D. certifies

Address Chestertown, Md. Date signed 3-28-47

ПОДАЧИ ВО ТЕЛЕГРАФНИ СТАЦИОНАР

СЪВЕТСКОГО ФЕДЕРАТИВНОГО СОЮЗА



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 921

CERTIFICATE OF DEATH

Reg. Dist. No. 2020

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

all time

Hospital, institution, or street address where death occurred:

Pomona - Chestertown P.D # 3

How long in hospital or institution?.....

3. (a) FULL NAME

Alfred Ringgold

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

Col.

Widowed

6. (b) Name of husband or wife.....

(late) Mary Ely Ringgold

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

March 5 1851

8. AGE:

Years

Months

Days

If less than one day

96

0

2

hrs.

min.

9. Birthplace.....

Pomona Kent Co. Maryland

(Town, county, and state)

10. Usual occupation.....

Labor

11. Industry or business

Yard Man

12. Name.....

Alfred Ringgold

13. Birthplace

Dudley Neck Kent Co. Md.

14. Maiden name.....

Louisa Smith

15. Birthplace

Dudley Neck, Kent Co. Md.

16. Informant.....

Lester Brown

17. Burial

Date thereof..... March 9, 1947

(Burial, cremation, or removal? Which?)

(month) (day) (year)

Cemetery or crematory

Dudley Neck

Location.....

Pomona Kent Co. Maryland

18. Funeral director.....

Marvin V. Williams

Address

Chestertown Maryland

19. March 9, 1947
(Date rec'd by registrar)

Clara S. Barnes.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Pomona

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Chestertown P.D # 3

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

March 7

1947 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 15 1947 to March 7 1947

and that I last saw him alive on March 7 1947

Immediate cause of death.....

old age

chron endo - my, exar, belis

Due to.....

Fracture neck of 6th rib

Arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

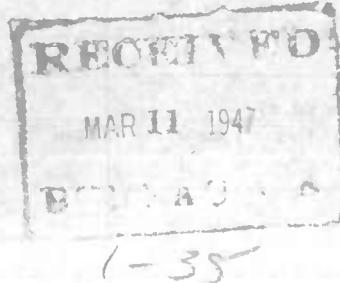
23. SIGNATURE.....

Oleer A. Buzard

M. D. or other

Address.....

Rock Hall Md Date signed 3/8/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1618

12942

CERTIFICATE OF DEATH

Reg. Diat. No. 2030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and briefly.

1. PLACE OF DEATH:

County

City or town

Kent
Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Junior Shaw

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age

years

March 20, 1947

8. AGE:

Years

Months

Days

If less than one day

9

hrs.

min.

9. Birthplace

Chestertown, Kent Co., Md.

(Town, county, and state)

10. Usual occupation.

11. Industry or business

12. Name

James Shaw

13. Birthplace

Unknown

14. Maiden name

Doris Emily Butter

15. Birthplace

Rock Hall, Md.

16. Informant

Doris E. Butter

Address

Rock Hall, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Mar. 31, 1947
(month) (day) (year)

Cemetery or crematory Sharptown (Co. 1.) Cemetery

Location near Rock Hall - Kent Co. Md.

18. Funeral director J. Willis Wells

Address

Chestertown, Md.

3/31

(Date rec'd by registrar)

19. 19.47

S. Edward Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Kent

City or town Chestertown, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

3-29

19. 47

at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-20

19. 47

to 3-28

19. 47

and that I last saw him alive on

3-28-47

19.

Immediate cause of death

Tetmphyse (neonatorum?)

DURATION

36 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

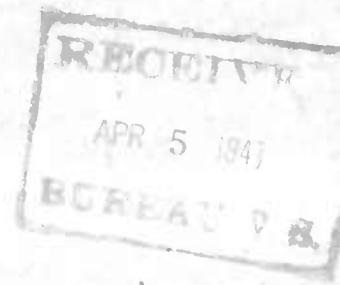
Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE.

Robert W. Farre
Chestertown, Md. Date signed 3-29-47M. D. *author*



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(B2)*

02944

CERTIFICATE OF DEATH

Reg. Dist. No. *91020*

1. PLACE OF DEATH:

County Kent

City or town Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Kent and Queen Anne Co. Hospital

How long in hospital or institution? 2 days

3. (a) FULL NAME

Henry G. Watson

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife Amelia Brown Watson

7. Birth date of deceased (mo., day, yr.) living 6.(c) If alive, give age years

Feb. 17, 1879

8. AGE: Years Months Days If less than one day
68 I 12 hrs. min.9. Birthplace Seneca County, Ohio
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name James Wesley Watson

13. Birthplace Fostoria, Ohio

14. Maiden name Anna Burns

15. Birthplace Ohio

16. Informant Mrs. Amelia Watson (wife)

Address Chestertown, Md.

17. Burial Date thereof Mar. 31, 1947
(Burial, cremation, or removal. Which?)

Cemetery or crematory Saint Paul Cem.

Location near Fairlee Kent Co. Md.

18. Funeral director J. Willis Wells

Address Chestertown, Md.

19. March 30, 1947
(Date rec'd by registrar)

Clara L. Barnes.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Fairlee
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947 at 12:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947 to March 28, 1947 and that I last saw her alive on March 28, 1947.

Immediate cause of death

Carpus Vasculor

DURATION

Due to Malnutrition Hypertension 7 year

Due to Arteriosclerosis 2 year

Other condition Lung m. Tumor 2 yrs

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Franklin Smith

M. D. 3/29/47

Address Clara L. Barnes Date signed 3/29/47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2d

CERTIFICATE OF DEATH

02945

Reg. Dist. No. 204

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex _____ 5. Color or race _____ 6. (a) Single, married, widowed, or divorced

Female widow

6. (b) Name of husband or - Sherman Niedel

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1897

8. AGE: Years _____ Months _____ Days _____ If less than one day
65 - - - - - hrs. _____ min.9. Birthplace..... Kent Co. Md.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Thomas Hodges

13. Birthplace..... Anderson

14. Maiden name..... Fernlene -

15. Birthplace.....

16. Informant..... Anna Somay daughter

Address..... Chestertown Rd. nd

17. Burial..... Date thereof..... March 20 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Sandy, Baltimore

Location..... "

18. Funeral director..... Asbury Henry

Address..... Chestertown Rd. nd

19. Date rec'd by registrar..... May 19 1947 F. G. Smith

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Chestertown Rd. nd

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 17 1947 at 9 45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to March 10 1947

and that I last saw her alive on March 10 1947

Immediate cause of death.....

Cerebral hemorrhage

Due to.....

Hypertension

Other conditions of heart

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

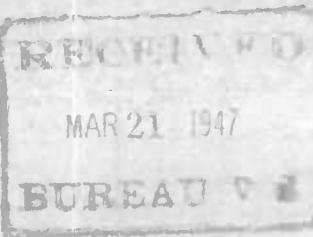
Means of Injury..... Injured at work?

23. SIGNATURE..... Frank G. Smith

M. D. or other.....

Address..... Chestertown Rd. nd

Date signed..... May 10 1947



1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9th

402946

CERTIFICATE OF DEATH

Reg. Dist. No. 2030

1. PLACE OF DEATH:

County..... Kent

City or town..... Rock Hall R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

A. Carroll Willson

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white widowed

6.(b) Name of husband or wife..... Gertrude H. Willson

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1860 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
86 25 hrs. min.9. Birthplace..... Kent Co., Maryland
(Town, county, and state)

10. Usual occupation..... farmer

11. Industry or business..... farm

FATHER 12. Name..... Alexander Willson

MOTHER 13. Birthplace..... Kent Co., Maryland

14. Maiden name..... Mary Tilden

15. Birthplace..... Kent Co., Maryland

16. Informant..... J. Ernest Willson (son)

Address..... Rock Hall, Maryland

17. Burial Date thereof Mar. 9, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Chestertown Saint Paul Cem.

Location..... near - Chestertown, Maryland

18. Funeral director..... J. Willis Wells

Address..... Chestertown, Maryland

19. March 8, 1947
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war..... NO

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 6 1947 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 13, 1946, to March 6, 1947,

and that I last saw him alive on around March 1, 1947.

Immediate cause of death..... Liver Encephalitis

Cerebral Hemorrhage

Due to..... Paralysis of right side

arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

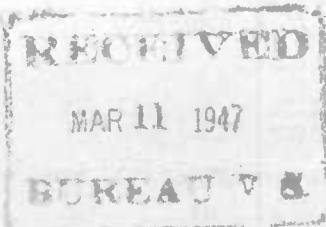
Injured at work?

23. SIGNATURE..... Alvert a Burgard M. D. another

Rock Hall, Md.

Date signed.....

March 8, 1947



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